

Benefit Payment Request



| | | | |
|---|-----------------------------|-----------------------------|-------------------------|
| Group Number: | | Plan Name: | |
| Participant's Name: (Last, First, M.I.) | | Date of Birth: | Social Security Number: |
| Participant's Address: | | | |
| City: | State: | Zip: | Daytime Phone Number: |
| Date of Final Payroll Deduction: | * Vesting %: Profit Sharing | * Vesting %: Employer Match | Date of Hire: |

* HARTFORD LIFE WILL PROCESS THIS BENEFIT PAYMENT IN ACCORDANCE WITH THE VESTING PERCENTAGES INDICATED ON THIS FORM.

A. REASON FOR BENEFIT PAYMENT

Required: Severance from Service Date:

- ☐ 1. Termination of Employment
☐ 2. Retirement
☐ 3. Permanent / Total Disability
☐ 4. Minimum Required Distribution
(If checked, go to Section B, number 5)

____/____/____

Note: For distributions due to severance from service, any outstanding loan balance will be reported as taxable to the extent it is not secured by employee after-tax basis.

B. METHOD / AMOUNT OF PAYMENT (Options available may vary according to the plan provisions.)

- ☐ 1. Lump sum cash payment of the total vested account balance
☐ 2. Partial lump sum payment (payments will first be distributed from after-tax sources if available) of \$ _____
☐ 3. Partial rollover of \$ _____ and, unless elected otherwise, pay any remaining vested account balance as a lump sum cash payment: ☐ Defer any remaining vested account balance
☐ 4. Direct Rollover of the vested account balance
☐ 5. Minimum Required Distribution payment of \$ _____

C. DIRECT ROLLOVER

I elect a Direct Rollover of my benefit payment as follows:

Direct Rollover to: ☐ Traditional IRA ☐ Employer's Eligible Retirement Plan

After-Tax Contributions: After-tax contributions may only be rolled over to another 401(a) qualified plan for Traditional IRA.

(Check if applicable): ☐ Exclude after-tax contributions from the Direct Rollover and pay directly to me.

Account Number: _____

Financial Institution or Plan Name: _____

Address: _____

D. DIRECTION AND AUTHORIZATION (Mandatory Distributions do not require Participant Signature)

I hereby consent to the payment indicated above. I acknowledge that I have read and understand the Special Tax Notice. I understand that for an eligible rollover distribution, if I do not elect a direct rollover, 20% mandatory Federal Income Tax withholding will apply. For a minimum required distribution, 10% Federal Income Tax withholding will apply unless I elect otherwise via the Withholding Authorization Form. I have reviewed the state income tax withholding section of the Withholding Authorization Form and understand that, if applicable, I must complete and return the form with this request. I also acknowledge that I have read and understand the Full Disclosure Statement, as applicable to my state.

Participant's Signature _____

Date _____

E. PLAN ADMINISTRATOR OR REPRESENTATIVE AUTHORIZATION (Required before submitting form to Hartford Life Insurance Company for processing)

(Check if applicable)

- ☐ **Mandatory Distribution** - In accordance with the terms of the plan, this distribution is to be made without the participant's consent. No participant signature required.

Hartford Life is directed to withdraw the amount necessary to pay the benefit as indicated above based on the vesting percentages* included on this form and in accordance with the terms of the plan. I certify that the above data in regard to the participant is true and accurate to the best of my knowledge and that I have obtained any spousal waiver consent forms that may be required by ERISA and the Internal Revenue Code. If the participant has an outstanding loan balance, please report the outstanding loan balance not secured by employee after-tax basis as taxable. If this is a mandatory distribution, please disregard this request if the participant's vested account balance at the time this request is received is greater than \$5,000 (rollover contributions are included in making this determination). If I have elected a direct rollover of a mandatory distribution, I certify that the plan has entered into an agreement with the IRA provider identified above to receive this mandatory distribution.

Plan Administrator's or Authorized Plan Representative Signature _____

Date _____

Full Disclosure Statement

Arkansas

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Colorado

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Services."

District of Columbia

"WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

Florida

"Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

Indiana

"A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

Kentucky

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

Louisiana

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

New Hampshire

"Any person who, with a purpose to injure, defraud or deceive any insurance Company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. However, the lack of such a statement shall not constitute a defense against prosecution under RSA 638:20."

New Jersey

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Ohio

"Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud."

Oklahoma

"WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

Pennsylvania

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."